LRB-4473

2003 DRAFTING REQUEST

Bill

Received: **03/11/2004**

Received By: **dkennedy**

Wanted: **As time permits**

Identical to LRB:

For: **Sheldon Wasserman (608) 266-7671**

By/Representing: **Sarah Osterberg**

This file may be shown to any legislator: **NO**

Drafter: **dkennedy**

May Contact:

Addl. Drafters: **pkahler**
mkunkel

Subject: **Health - miscellaneous**
Insurance - miscellaneous
Occupational Reg. - misc

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Wasserman@legis.state.wi.us**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Multiple health, occupational regulation, and insurance provisions

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Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?				_____			S&L
/P1	dkennedy 03/11/2004	kfollett 03/11/2004		_____ _____			S&L

LRB-4473

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/1			chaugen 03/11/2004	_____ _____	sbasford 03/11/2004	sbasford 03/11/2004	

FE Sent For:

<END>

AA intro

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See Attached

PLEASE JACKET!

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	dkennedy	11 KJF 3/11	Crmd 3-11 CH KJF 3-11	3-11 JF			

FE Sent For:

<END>

Kennedy, Debora

From: Osterberg, Sarah
Sent: Thursday, March 11, 2004 11:40 AM
To: Kennedy, Debora
Subject: URGENT drafting request

Debora,

Sheldon told me to put in this request yesterday and I ran out of time. The Dem leadership in the assembly wants the following drafted into one bill ASAP:

AB 896 -4180 DAK
AB 129 -0876 PJK
AB 450 -0293 DAK + AA1 = a 2008
AB 11 -0083 MDK + AA1 = a 0432
AB 16 -0082-~~0840~~ MDK + AA1 = a 0840 +ccc
AB 920 -4038 DAK
AB 509 -0081 MDK
AB 895 -2171 DAK
AB 772 -0287 DAK
AB 690 -2923 PJK
SB 71 -~~1996~~ PJK 4203
SB 72 -~~4994~~ PJK 4204

Also require that any Wisconsin MA vendor must maintain a separate unit for processing dental forms.

+

AB 36 -0288 DAK

Kennedy, Debora

From: Osterberg, Sarah
Sent: Thursday, March 11, 2004 12:02 PM
To: Kennedy, Debora
Subject: RE: URGENT drafting request: read this one

just to clarify, draft all bills as is, except for AB 450, AB 11, and AB 16, which are as amended. THANKS!!!!

-----Original Message-----
From: Osterberg, Sarah
Sent: Thursday, March 11, 2004 11:45 AM
To: Kennedy, Debora
Subject: URGENT drafting request: read this one

also include ab 36. thanks.

-----Original Message-----
From: Osterberg, Sarah
Sent: Thursday, March 11, 2004 11:40 AM
To: Kennedy, Debora
Subject: URGENT drafting request

Debora,

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AB 896
AB 129
AB 450
AB 11
AB 16
AB 920
AB 509
AB 895
AB 772
AB 690
SB 71
SB 72

Also require that any Wisconsin MA vendor must maintain a separate unit for processing dental forms.

State of Wisconsin
2003 – 2004 LEGISLATURE

LRBa2008/1
DAK:kmg:rs

ASSEMBLY AMENDMENT 1,

TO 2003 ASSEMBLY BILL 450

January 23, 2004 – Offered by Representative WASSERMAN.

At the locations indicated, amend the bill as follows:

1. Page 1, line 4: delete "and making an appropriation".

2. Page 3, line 10: delete "appropriation under s. 20.435 (4) (b)" and substitute "appropriation accounts under s. 20.435 (4) (b) and (o)".

(END)

-4473

Kennedy, Debora

From: Osterberg, Sarah
Sent: Thursday, March 11, 2004 11:40 AM
To: Kennedy, Debora
Subject: URGENT drafting request

Debora,

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AB 129 -0876 PJK
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AB 11 -0083 MDK + AA1 = a 0432
AB 16 ~~-0840 MDK~~ + AA1 = a 0840 +ccc
AB 920 -4038 DAK
AB 509 -0081 MDK
AB 895 -2171 DAK
AB 772 -0287 DAK
AB 690 -2923 PJK
SB 71 ~~-1978~~ PJK -4203
SB 72 ~~-1924~~ PJK -4204

-0082

Also require that any Wisconsin MA vendor must maintain a separate unit for processing dental forms.

+

AB 36 -0288 DAK

Sorted Item List

Store File Name	Text
–0293.1	20.435 (4) (b) of the statutes is amended to read:
–0293.2	20.435 (7) (bd) of the statutes is amended to read:
–0083.1	46.03 (44) of the statutes is created to read:
–4038.1	46.277 (1) of the statutes is amended to read:
–4038.2	46.277 (1m) (a) of the statutes is renumbered 46.277 (1m) (ak).
–4038.3	46.277 (1m) (ag) of the statutes is created to read:
–4038.4	46.277 (2) (intro.) of the statutes is amended to read:
–4038.5	46.277 (3) (a) of the statutes is amended to read:
–4038.6	46.277 (3) (b) 1. of the statutes is amended to read:
–4038.7	46.277 (3) (b) 2. of the statutes is amended to read:
–4038.8	46.277 (4) (a) of the statutes is amended to read:
–4038.9	46.277 (4) (b) of the statutes is amended to read:
–4038.10	46.277 (4) (c) of the statutes is created to read:
–4038.11	46.277 (5) (g) of the statutes, as created by 2003 Wisconsin Act 33, is amended to read:
–4038.12	46.277 (5g) (a) of the statutes is amended to read:
–0293.3	49.45 (6ur) of the statutes is created to read:
–0293.4	49.45 (6v) of the statutes is renumbered 49.45 (6L).
–0876.1	49.46 (1) (a) 1. of the statutes is amended to read:
–0876.2	49.46 (1) (a) 1g. of the statutes is amended to read:
–0876.3	49.46 (1) (a) 1m. of the statutes is amended to read:
–0876.4	49.46 (1) (a) 6. of the statutes is amended to read:
–0876.5	49.46 (1) (a) 9. of the statutes is amended to read:
–0876.6	49.46 (1) (a) 10. of the statutes is amended to read:
–0876.7	49.46 (1) (a) 11. of the statutes is amended to read:
–0876.8	49.46 (1) (a) 12. of the statutes is amended to read:
–0876.9	49.46 (1) (ar) of the statutes is created to read:
–0876.10	49.46 (1) (e) of the statutes is amended to read:
–0876.11	49.46 (1) (L) of the statutes is repealed.
–0876.12	49.47 (4) (am) 1. of the statutes is amended to read:

–0876.13	49.47 (4) (am) 2. of the statutes is amended to read:
–0876.14	49.47 (4) (c) 1. of the statutes is amended to read:
–0876.15	49.47 (4) (c) 3. of the statutes is amended to read:
–0876.16	49.47 (4) (cg) 3. of the statutes is created to read:
–0876.17	49.47 (4) (h) of the statutes is renumbered 49.47 (4) (cg) 2. and amended to read:
–0876.18	49.665 (4) (a) 1. of the statutes is amended to read:
–0876.19	49.665 (4) (d) of the statutes is created to read:
–4180.1	49.688 (4r) of the statutes is created to read:
–0288.1	51.30 (4) (b) 13. of the statutes is renumbered 51.30 (4) (cm) and amended to read:
–0081.1	100.31 (title) of the statutes is amended to read:
–0081.2	100.31 (1) (a) of the statutes is renumbered 100.31 (1) (bm) and amended to read:
–0081.3	100.31 (1) (ae) of the statutes is created to read:
–0081.4	100.31 (1) (as) of the statutes is created to read:
–0081.5	100.31 (1) (b) of the statutes is renumbered 100.31 (1) (am) and amended to read:
–0081.6	100.31 (1) (c) of the statutes is amended to read:
–0081.7	100.31 (2) of the statutes is amended to read:
–0081.8	100.31 (2r) of the statutes is created to read:
–0081.9	100.31 (4) of the statutes is amended to read:
–2171.1	146.385 of the statutes is created to read:
–0289.1	146.89 (1) of the statutes is renumbered 146.89 (1) (intro.) and amended to read:
–0289.2	146.89 (1) (d) of the statutes is created to read:
–0289.3	146.89 (1) (g) of the statutes is created to read:
–0289.4	146.89 (1) (h) of the statutes is created to read:
–0289.5	146.89 (2) (a) of the statutes is amended to read:
–0289.6	146.89 (2) (c) of the statutes is amended to read:
–0289.7	146.89 (2) (d) of the statutes is amended to read:
–0289.8	146.89 (3) (b) (intro.) of the statutes is amended to read:
–0289.9	146.89 (3) (c) of the statutes is amended to read:
–0289.10	146.89 (3) (d) (intro.) of the statutes is amended to read:
–0289.11	146.89 (3m) of the statutes is created to read:

–0083.2	441.07 (1) (d) of the statutes is amended to read:
–0083.3	441.16 (3m) of the statutes is created to read:
–0083.4	448.015 (4) of the statutes is amended to read:
–0083.5	448.035 of the statutes is created to read:
–0083.6	448.04 (1) (a) of the statutes is amended to read:
–0083.7	450.10 (1) (a) (intro.) of the statutes is amended to read:
–0083.8	450.11 (1) of the statutes is amended to read:
–0083.9	450.11 (1g) of the statutes is created to read:
–0082.1	456.02 (intro.) of the statutes is amended to read:
–0082.2	456.02 (1) of the statutes is amended to read:
–0082.3	456.02 (2) of the statutes is amended to read:
–0082.4	456.02 (3) of the statutes is amended to read:
–0082.5	456.02 (4) of the statutes is amended to read:
–0082.6	456.02 (5) of the statutes is amended to read:
–0082.7	456.02 (6) of the statutes is amended to read:
–0082.8	456.02 (7) of the statutes is amended to read:
–0082.9	456.04 (4) of the statutes is repealed and recreated to read:
–0082.10	456.04 (5) of the statutes is created to read:
–0082.11	456.07 (5) of the statutes is amended to read:
–0082.12	456.08 of the statutes is renumbered 456.08 (intro.) and amended to read:
–0082.13	456.08 (1), (2), (3) and (4) of the statutes are created to read:
–0082.14	456.09 (1) (c) of the statutes is amended to read:
–0082.15	456.12 of the statutes is created to read:
–2923.1	609.22 (2) of the statutes is amended to read:
–2923.2	609.32 (2) (a) of the statutes is amended to read:
–2923.3	628.36 (1) of the statutes is renumbered 628.36 (1m) and amended to read:
–2923.4	628.36 (1c) (intro.) of the statutes is created to read:
–2923.5	628.36 (2) (a) (intro.) of the statutes is amended to read:
–2923.6	628.36 (2) (b) 3. of the statutes is amended to read:
–2923.7	628.36 (2) (b) 4. of the statutes is amended to read:
–2923.8	628.36 (2) (b) 4m. of the statutes is created to read:
–2923.9	628.36 (2m) (title) of the statutes is repealed and recreated to read:
–2923.10	628.36 (2m) (a) (intro.) and 2m. of the statutes are consolidated, renumbered 628.36 (2m) (ac) and amended to read:

–2923.11	628.36 (2m) (a) 1. of the statutes is renumbered 628.36 (1c) (a).
–2923.12	628.36 (2m) (a) 2. of the statutes is renumbered 628.36 (1c) (b).
–2923.13	628.36 (2m) (a) 3. of the statutes is renumbered 628.36 (1c) (c).
–2923.14	628.36 (2m) (e) 1. of the statutes is amended to read:
–2923.15	628.36 (2m) (e) 2. of the statutes is amended to read:
–2923.16	628.36 (2m) (e) 3. of the statutes is amended to read:
–2923.17	628.36 (2m) (e) 4. of the statutes is repealed.
–2923.18	628.36 (3) of the statutes is amended to read:
–4204.1	632.89 (1) (am) of the statutes is created to read:
–4203.1	632.89 (1) (b) of the statutes is created to read:
–4204.2	632.89 (2) (b) 1. of the statutes is amended to read:
–4204.3	632.89 (2) (c) 2. b. of the statutes is amended to read:
–4204.4	632.89 (2) (d) 2. of the statutes is amended to read:
–4204.5	632.89 (2) (dm) 2. of the statutes is amended to read:
–4204.6	632.89 (2) (f) of the statutes is created to read:
–4203.2	632.89 (6) and (7) of the statutes are created to read:
–0289.12	895.48 (1m) of the statutes, as affected by 2003 Wisconsin Act 33, is renumbered 895.48 (1m) (a).
–0289.13	895.48 (1m) (b) of the statutes is created to read:
–4180.2	Initial applicability.
–4180.3	Effective date.
–4203.3	Initial applicability.
–0293.5	Effective date.
–4204.7	Initial applicability.
–0081.10	Effective date.
–0083.10	Nonstatutory provisions.
–0083.11	Effective dates. This act takes effect on the first day of the 13th month beginning after publication, except as follows:
–0289.14	Initial applicability.
–0082.16	Initial applicability.
–0082.17	Effective dates. This act takes effect on the first day of the 7th month beginning after publication, except as follows:
–0876.20	Initial applicability.

State of Wisconsin
2003 – 2004 LEGISLATURE

LRB–4473/A1
DAK:...:ch

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

AN ACT *to repeal* 49.46 (1) (L) and 628.36 (2m) (e) 4.; *to renumber* 46.277 (1m) (a), 49.45 (6v), 628.36 (2m) (a) 1., 628.36 (2m) (a) 2., 628.36 (2m) (a) 3. and 895.48 (1m); *to renumber and amend* 49.47 (4) (h), 51.30 (4) (b) 13., 100.31 (1) (a), 100.31 (1) (b), 146.89 (1), 456.08 and 628.36 (1); *to consolidate, renumber and amend* 628.36 (2m) (a) (intro.) and 2m.; *to amend* 20.435 (4) (b), 20.435 (7) (bd), 46.277 (1), 46.277 (2) (intro.), 46.277 (3) (a), 46.277 (3) (b) 1., 46.277 (3) (b) 2., 46.277 (4) (a), 46.277 (4) (b), 46.277 (5) (g), 46.277 (5g) (a), 49.46 (1) (a) 1., 49.46 (1) (a) 1g., 49.46 (1) (a) 1m., 49.46 (1) (a) 6., 49.46 (1) (a) 9., 49.46 (1) (a) 10., 49.46 (1) (a) 11., 49.46 (1) (a) 12., 49.46 (1) (e), 49.47 (4) (am) 1., 49.47 (4) (am) 2., 49.47 (4) (c) 1., 49.47 (4) (c) 3., 49.665 (4) (a) 1., 100.31 (title), 100.31 (1) (c), 100.31 (2), 100.31 (4), 146.89 (2) (a), 146.89 (2) (c), 146.89 (2) (d), 146.89 (3) (b) (intro.), 146.89 (3) (c), 146.89 (3) (d) (intro.), 441.07 (1) (d), 448.015 (4), 448.04 (1) (a), 450.10 (1) (a) (intro.), 450.11 (1), 456.02 (intro.), 456.02 (1), 456.02 (2), 456.02 (3), 456.02 (4), 456.02 (5), 456.02 (6), 456.02 (7), 456.07 (5), 456.09 (1) (c), 609.22 (2), 609.32 (2) (a), 628.36 (2) (a) (intro.), 628.36 (2) (b) 3., 628.36

(2) (b) 4., 628.36 (2m) (e) 1., 628.36 (2m) (e) 2., 628.36 (2m) (e) 3., 628.36 (3), 632.89 (2) (b) 1., 632.89 (2) (c) 2. b., 632.89 (2) (d) 2. and 632.89 (2) (dm) 2.; ***to repeal and recreate*** 456.04 (4) and 628.36 (2m) (title); and ***to create*** 46.03 (44), 46.277 (1m) (ag), 46.277 (4) (c), 49.45 (6ur), 49.46 (1) (ar), 49.47 (4) (cg) 3., 49.665 (4) (d), 49.688 (4r), 100.31 (1) (ae), 100.31 (1) (as), 100.31 (2r), 146.385, 146.89 (1) (d), 146.89 (1) (g), 146.89 (1) (h), 146.89 (3m), 441.16 (3m), 448.035, 450.11 (1g), 456.04 (5), 456.08 (1), (2), (3) and (4), 456.12, 628.36 (1c) (intro.), 628.36 (2) (b) 4m., 632.89 (1) (am), 632.89 (1) (b), 632.89 (2) (f), 632.89 (6) and (7) and 895.48 (1m) (b) of the statutes; **relating to:** treating property taxes as a deduction to annual household income for purposes of determining eligibility and deductible amounts under the prescription drug assistance program for the elderly; exempting amounts claimed for depreciation for purposes of calculating farm and self–employment income under the Medical Assistance and Badger Care health care programs; requiring Medical Assistance incentive payments to hospitals that establish a physician order entry record system; prescriptions for antibiotic drugs for treatment of chlamydia, gonorrhea, or trichomonas ~~and requiring the exercise of rule–making authority;~~ the requirements for examinations for nursing home administrator licenses and for reciprocal nursing home administrator licenses; and creating an exemption from such requirements; provision of home and community–based services under a community integration program to persons relocated from facilities ~~during the period of the relocation~~; discrimination in prescription drug prices; health care provider service rates and insurer health care services reimbursement rates; expanding the Volunteer Health Care Provider Program to include provision of services to students from 4–year–old kindergarten to grade 6 in public

elementary schools, charter schools, and private schools that participate in the Milwaukee Parental Choice Program; allowing any provider to participate in a health care plan under the terms of the plan, requiring an annual period for providers to elect to participate in health care plans, and requiring notice to a provider of the reason for exclusion from a health care plan; treatment of prescription drug costs, diagnostic testing, and payments under mandated insurance coverage of treatment for nervous and mental disorders and alcoholism and other drug abuse problems; increasing the limits for insurance coverage of nervous or mental health disorders or alcoholism or other drug abuse problems; an exception to confidentiality requirements for treatment records; granting rule–making authority; ~~and making an appropriation~~.

and requiring the exercise of rule-making authority

Analysis by the Legislative Reference Bureau

***ANALYSIS FROM 4180/1 ***

Under current law, elderly persons may purchase prescription drugs at reduced amounts under a program commonly known as "Senior Care." A person is eligible for Senior Care if he or she is a state resident, is at least 65 years of age, is not a medical assistance (MA) recipient or does not receive prescription drug coverage as an MA recipient, and his or her annual household income, as determined by the Department of Health and Family Services (DHFS), does not exceed 240 percent of the federal poverty line. A person must pay an annual $30 fee to enroll in Senior Care. An enrollee pays the "program payment rate" for prescription drugs (105 percent of the MA prescription drug payment rate plus a dispensing fee) until the enrollee has met an annual deductible, if applicable, and thereafter pays only a copayment of $5 for generic prescription drugs and a copayment of $15 for nongeneric prescription drugs. A person whose annual household income is 160 percent or less of the federal poverty line pays no deductible; if the person's annual household income is more than 160 percent but not more than 200 percent of the federal poverty line, the deductible is $500; and if the person's annual household income exceeds 200 percent of the federal poverty line, the deductible is $850. Other persons who meet all of the requirements except the income limitation are also eligible to purchase prescription drugs for the $5 and $15 copayment amounts for the time remaining in a 12–month period after spending the difference between their annual household income and 240 percent of the federal poverty line by paying for prescription drugs

at the retail price and satisfying the $850 deductible by purchasing prescription drugs at the program payment rate.

This bill requires that in determining a person's annual household income for purposes of Senior Care eligibility, DHFS must deduct the amount that the person paid in property taxes on his or her primary residence in the previous 12 months. DHFS must also use the annual household income adjusted for property taxes to determine the appropriate deductible amount for persons who are enrolled in Senior Care.

*** ANALYSIS FROM –0876/1 ***

Currently, the Department of Health and Family Services (DHFS) administers the Medical Assistance (MA) and Badger Care health care (BadgerCare) programs.

Under part of the MA program, DHFS provides health care services and benefits to individuals who meet the requirements under one of the following MA eligibility categories:

1. *AFDC–MA.* Under this category, an individual who meets the nonfinancial and financial requirements for the federal Aid to Families with Dependent Children (AFDC) program that were in effect on July 16, 1996, without regard to the individual's assets, is eligible to receive MA. The AFDC program was replaced with the federal Temporary Assistance for Needy Families (TANF) program on July 16, 1996. Generally, individuals who qualify under the AFDC–MA category are certain children under 19 years of age, their caretaker relatives, and pregnant women in the eighth or ninth month of pregnancy.

2. *AFDC–related MA.* This category includes certain children under the age of 19, their caretaker relatives, and pregnant women throughout the entire pregnancy who meet the income requirements of the AFDC program that were in effect on July, 16, 1996, without regard to assets, but who would not have received an AFDC payment. Also eligible under this category are children under the age of 18 and pregnant women whose incomes do not exceed 133.33% of the maximum payment under the AFDC program, and whose assets do not exceed certain asset limits.

3. *Healthy Start.* This category includes children between the ages of six and 19 whose incomes do not exceed 100% of the federal poverty line, children under the age of six and pregnant women whose incomes do not exceed 133.33% of the federal poverty line, and children under the age of six and pregnant women whose incomes do not exceed 185% of the federal poverty line.

The BadgerCare program provides health care coverage to eligible low–income children who do not reside with a parent and to eligible low–income families. A child or family is generally considered low–income if the child's or family's income does not exceed 185% of the poverty line.

Currently, in calculating an individual's income for the MA or BadgerCare program, if the individual has farm or self–employment income, DHFS calculates the amount of that income by adding the amount that the individual claimed for depreciation to the amount of the individual's net taxable income.

This bill prohibits DHFS from adding any amounts claimed for depreciation to an individual's net taxable farm or self–employment income for purposes of

determining whether an individual meets the income limits for the MA program under the AFDC–MA, AFDC–related MA, or Healthy Start eligibility categories or for the BadgerCare program.

~~***ANALYSIS FROM -0293/2***~~

Beginning on January 1, 2005, or the day after publication of this bill as an act, whichever is later, this bill requires that, for each hospital that establishes and maintains a physician order entry record system for medical services, ~~the Department of Health and Family Services~~ annually make an incentive ~~Medical Assistance (MA)~~ payment that equals 1% of the MA reimbursement to the hospital for the previous fiscal year. The hospital must establish the physician order entry record system by January 1, 2007.

~~***ANALYSIS FROM -0083/1***~~

This bill allows a physician, physician assistant, or advanced practice nurse to prescribe to a patient an antibiotic drug as a course of therapy for the treatment of chlamydia, gonorrhea, or trichomonas for use by a person with whom the patient has had sexual intercourse if the patient states that the person is not allergic to the drug. Such a prescription may be made for no more than two people in one year with whom the patient has had sexual intercourse. Also, such a prescription may not be made for a controlled substance.

A physician, physician assistant, or advanced practice nurse who makes such a prescription may provide the patient with written information specified in rules promulgated by ~~the Department of Health and Family Services~~. The information must include information about sexually transmitted diseases and their treatment and about the risk of drug allergies. In addition, the physician, physician assistant, or advanced practice nurse may request that the patient provide the written information to the person with whom he or she has had sexual intercourse.

~~This is a preliminary draft. An analysis will be provided in a later version.~~

~~***ANALYSIS FROM -0082/1***~~

This bill makes changes to current law regarding the following: 1) the requirements for a nursing home administrator license; 2) the requirements for a reciprocal nursing home administrator license that apply to persons licensed in other states; and 3) the requirement to be licensed as a nursing home administrator.

~~*Requirements for a nursing home administrator license.*~~ Under current law, a person must satisfy certain education requirements before he or she is allowed to take the examination for a nursing home administrator license. Specifically, he or she must complete a regular course of study, equivalent specialized courses, or a program of study that is considered adequate academic preparation for nursing home administration by the Nursing Home Administrator Examining Board ~~(examining board)~~. In addition, the examining board is required to develop and enforce standards regarding the supervised practical experience that is required for a person to be licensed as a nursing home administrator. A person may satisfy the supervised practical experience requirements before or after taking the examination.

This bill changes the requirements that a person must satisfy before taking the nursing home administrator examination. Under the bill, a person must satisfy

certain education and supervised practical experience requirements before he or she can take the examination. Regarding education, the bill requires a person to have either: 1) a bachelor's, master's, or doctoral degree with a health care administration or long–term care major; or 2) a bachelor's degree and completion of a specialized course in nursing home administration. The bill directs the examining board to promulgate rules establishing the supervised practical experience requirements. The rules must require a person to complete at least 2,000 hours in an internship, administrator–in–training program, or other structured program before he or she can take the examination. The 2,000 hours must be completed in any consecutive three–year period within the five–year period immediately preceding the date of application for the examination.

Reciprocal licenses. Under current law, a person who has a nursing home administrator license in another state is eligible for a reciprocal nursing home administrator license if he or she satisfies certain requirements, including submitting satisfactory evidence of the person's qualifications to the examining board. This bill specifies the qualifications that a person must have to be eligible for a reciprocal license. Under the bill, an applicant for such a license must have a bachelor's degree or be certified as a nursing home administrator by the American College of Health Care Administrators and must have practiced as a nursing home administrator in good standing for at least 2,000 hours in any consecutive three–year period within the five–year period immediately preceding the date of application for the reciprocal license. Also, the applicant must not have an arrest or conviction record the circumstances of which substantially relate to nursing home administration. In addition, the person must pass an examination relating to state and federal laws governing the practice of nursing home administration.

Exemption from licensure. Finally, current law prohibits a person from practicing as a nursing home administrator unless he or she is licensed by the examining board. This bill creates an exception for a [redacted] of a nursing home operated by adherents of a church or religious denomination, if that church or denomination subscribes to healing by prayer and is opposed to medical treatment.

ANALYSIS FROM -4038/1

Currently, the Department of Health and Family Services (DHFS) administers a Community Integration Program (commonly known as "CIP II"), under which Medical Assistance (MA) moneys are paid to counties to provide home and community–based services, under a waiver of federal Medicaid laws, to elderly and physically disabled persons who meet the level of care requirements for MA–reimbursed nursing home care or are relocated from facilities. DHFS must establish a uniform daily rate for CIP II and reimburse counties up to that rate for each person enrolled in CIP II. Under 2003 Wisconsin Act 33 (the biennial budget act), DHFS may provide enhanced reimbursement for CIP II services for a person who is relocated to the community from a nursing home by a county after July 16, 2003, if the nursing home bed used by the person is delicensed upon the person's relocation.

This bill authorizes DHFS to provide CIP II funding for home and community–based services to an MA–eligible person who relocates from a facility to the community. Reimbursement is not conditioned on delicensure of a nursing home bed upon the person's relocation. The funding begins on the date of the relocation and ends on the date that the person discontinues program participation or no longer meets the level of care requirements for MA reimbursement in a nursing home. Funding in the aggregate for these relocated persons may not exceed the total MA costs for the persons if served in nursing homes. DHFS may provide an enhanced reimbursement rate for the services. The total number of persons who may participate in this particular aspect of CIP II is not restricted by limitations on numbers participating in the remainder of CIP II.

~~*** ANALYSIS FROM -008172 ***~~

The bill changes a prohibition under current law against price discrimination that applies to a seller who trades in prescription drugs for resale. Under current law, the prohibition applies to a seller who sells prescription drugs directly to consumers. Under the bill, the prohibition applies to a seller who sells to a "dispenser," which the bill defines as a person who delivers a prescription drug to an ultimate user for outpatient use, including an insurer that issues certain types of managed health care plans. Also included under the definition of "dispenser" is a hospital that directly or indirectly bills a patient for prescription drugs.

The prohibition on price discrimination under current law applies to prescription drugs on a list of therapeutically equivalent drugs published by the federal Food and Drug Administration (FDA). This bill provides that the prohibition applies to drugs included in the most current version of either of the following: 1) the FDA list; or 2) another publication specified in rules promulgated by the Department of Agriculture, Trade and Consumer Protection that identifies drug products approved on the basis of safety and effectiveness by the FDA under the federal Food, Drug, and Cosmetic Act.

~~*** ANALYSIS FROM -217[illegible]3 ***~~

This bill requires ~~the Department of Health and Family Services~~ (DHFS) annually by April 1 to make available, on the DHFS website and, upon request, by mail, the current ~~Medical Assistance~~ (MA) fee schedule for services of health care providers (as defined in the bill). The bill requires health care providers, annually by April 15, to provide to DHFS a statement of the providers' rates for health care services for the following May 1 to April 30. Health care providers must also inform DHFS, during this period, of any increase in any of their rates over the amounts provided to DHFS. The rates must be stated in a form, as determined by DHFS, that may include statement as a percentage of the MA fee schedule. In addition, health care providers, annually beginning on May 1, must post their rates on an Internet website, if the health care provider has such a website, and take reasonable steps to ensure that their health care services consumers are aware that rate information is available and are informed about how to obtain the information. Any increase in a health care provider's rates is chargeable only after the health care provider has notified DHFS and, if the health care provider has a website, has posted information on the website about the rate increase.

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The bill requires insurers, annually by April 15, to provide to DHFS and to the insurers' insureds a statement of the insurers' rates of reimbursement for health care provider services for the following May 1 to April 30, stated as a percentage of the MA fee schedule. Insurers must also inform DHFS, during this period, of any increase in any of their rates over the amounts provided to DHFS.

DHFS may make available, on the DHFS website and, upon request, by mail, the health care provider rate and insurer reimbursement rate information, including increases, provided to DHFS. DHFS is also authorized to contract for the receipt and posting of this information and the current MA fee schedule for health care provider services, in accordance with DHFS request–for–proposal procedures.

*** ANALYSIS FROM 2023 ***

Under current law, if the Department of Administration (DOA) has approved a joint application of a health care provider and a nonprofit agency, the health care provider acting within the scope of his or her licensure or certification may provide, without charge to low–income, uninsured persons at the agency, diagnostic tests, health education, office visits, patient advocacy, prescriptions, information about available health care resources, referrals to health care specialists, and, for dentists, simple tooth extractions and necessary related suturing. The health care provider, for the provision of these services, is a state agent of ~~the Department of Health and Family Services~~; as such, for a civil action arising out of an act committed in the lawful course of the health care provider's duties, certain time limitations for filing the action apply, legal counsel is provided to the health care provider, judgments against the health care provider are paid by the state, and amounts recoverable are capped at $250,000.

This bill expands the Volunteer Health Care Provider Program to authorize provision of services, without charge, from four–year–old kindergarten to grade six in a public elementary school, a charter school, or a private school participating in the Milwaukee Parental Choice Program (MPCP), if DOA approves the joint application of a health care provider and a school board or the governing body of a charter school or a private school participating in MPCP. After providing to the school board or relevant governing body proof of satisfactory completion of any relevant competency requirements, the volunteer health care provider may provide without charge to students from four–year–old kindergarten to grade six of the school, regardless of income, diagnostic tests; health education; information about available health care resources; office visits; patient advocacy; referrals to health care specialists; first aid for illness or injury; in compliance with the written instructions of a pupil's parent or guardian, the administration of any drug, other than a contraceptive drug, that may lawfully be sold over the counter; health screenings; any other health care services designated by the Department of Public Instruction (DPI); and, for dentists, simple tooth extractions and necessary related suturing. However, the volunteer health care provider may not provide emergency medical services, hospitalization, or surgery, except as designated by DPI by rule, and may not provide abortion referrals, contraceptives, or pregnancy tests.

*** ANALYSIS FROM 2923 ***

Under current law, a health care plan must allow any provider to participate in the plan under the terms of the plan. However, this requirement does not apply to health maintenance organizations, limited service health organizations, or preferred provider plans, each of which is a health care plan that requires, or provides incentives for, its enrollees to obtain health care services from providers participating in the plan. "Participating" is defined as being under contract to provide health care services, items, or supplies to plan enrollees.

This bill requires any health care plan, including a health maintenance organization, limited service health organization, or preferred provider plan, to allow any provider to participate in the plan under the terms of the plan. The requirement only applies to a health maintenance organization, limited service health organization, or preferred provider plan, however, if the provider is located in the geographic service area of the plan. The bill also requires a health care plan that excludes a provider from participation in the plan to give the provider written notice of the reason for the exclusion.

Also under current law, a health maintenance organization, limited service health organization, or preferred provider plan that covers pharmaceutical services provided by one or more pharmacists who are not full–time salaried employees or partners of the organization or plan must provide an annual 30–day period during which any pharmacist may elect to participate in the organization or plan under its terms as a selected provider for at least one year. This bill expands that requirement. Under the bill, a health maintenance organization, limited service health organization, or preferred provider plan that covers health care services that are provided by one or more health care professionals who are not full–time salaried employees or partners of the organization or plan is required to provide an annual 30–day period during which any health care professional who provides those health care services and who is located in the geographic service area of the organization or plan may elect to participate in the organization or plan under its terms as a selected provider for at least one year.

~~*** ANALYSIS FROM -4203/1 ***~~

Under current law, a group health insurance policy ~~(called a "disability insurance policy" in the statutes)~~ that provides coverage of any inpatient hospital services must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of the lesser of: 1) the expenses of 30 days of inpatient services; or 2) $7,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $6,300 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage of any outpatient hospital services, it must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of $2,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $1,800 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage of any inpatient or outpatient hospital services, it must cover the cost of transitional treatment arrangements (services, specified by rule by the commissioner of insurance, that are provided in a less restrictive manner than

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inpatient services but in a more intensive manner than outpatient services) for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of $3,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $2,700 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage for both inpatient and outpatient hospital services, the total coverage for all types of treatment for nervous and mental disorders and alcoholism and other drug abuse problems is not required to exceed $7,000, or the equivalent benefits measured in services rendered, in a policy year.

This bill specifies that the minimum coverage limits required for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems do not include costs incurred for prescription drugs and diagnostic testing. Diagnostic testing is defined in the bill as procedures used to exclude the existence of conditions other than nervous or mental disorders or alcoholism or other drug abuse problems. The Department of Health and Family Services is authorized to specify, by rule, the diagnostic testing procedures that are not included under the coverage limits.

The bill also provides that, if an insurer pays less than the amount that a provider charges, the required minimum coverage limits apply to the amount actually paid by the insurer rather than to the amount charged by the provider.

ANALYSIS FROM 4264/P2

Under current law, a group health insurance policy called a "disability insurance policy" in the statutes that provides coverage of any inpatient hospital services must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of the lesser of: 1) the expenses of 30 days of inpatient services; or 2) $7,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $6,300 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage of any outpatient hospital services, it must cover those services for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of $2,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $1,800 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage of any inpatient or outpatient hospital services, it must cover the cost of transitional treatment arrangements (services, specified by rule by the commissioner of insurance, that are provided in a less restrictive manner than inpatient services but in a more intensive manner than outpatient services) for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems in the minimum amount of $3,000 minus the applicable cost sharing under the policy or, if there is no cost sharing under the policy, $2,700 in equivalent benefits measured in services rendered. If a group health insurance policy provides coverage for both inpatient and outpatient hospital services, the total coverage for all types of treatment for nervous and mental disorders and alcoholism and other drug abuse problems is not required to exceed $7,000, or the equivalent benefits measured in services rendered, in a policy year.

The bill changes the minimum amount of coverage that must be provided for the treatment of nervous and mental disorders and alcoholism and other drug abuse problems on the basis of the change in the consumer price index for medical services since the coverage amounts in current law were enacted. Inpatient services must be covered in the minimum amount of the lesser of: 1) the expenses of 30 days of inpatient services; or 2) $16,800 minus the applicable cost sharing or, if there is no cost sharing under the policy, $15,100 in equivalent benefits measured in services rendered. Outpatient services must be covered in the minimum amount of $3,100 minus the applicable cost sharing or, if there is no cost sharing under the policy, $2,800 in equivalent benefits measured in services rendered. Transitional treatment arrangements must be covered in the minimum amount of $4,600 minus the applicable cost sharing or, if there is no cost sharing under the policy, $4,100 in equivalent benefits measured in services rendered. The total coverage for all types of treatment for nervous and mental disorders and alcoholism and other drug abuse problems is not required to exceed $16,800, or the equivalent benefits measured in services rendered, in a policy year.

The table below provides information on treatment category, current minimum coverage amount, year of enactment, and the proposed coverage amounts based on the increase in the federal cost–of–living for medical coverage "indexed" since the enactment of the current coverage amounts.

Treatment	*Current Minimum Coverage Amount*	*Year Enacted*	*Proposed Coverage Amounts*
Inpatient			
Cost–sharing	$7,000*	1985	$16,800*
No cost–sharing	$6,300	1985	$15,100
Outpatient			
Cost–sharing	$2,000*	1992	$ 3,100*
No cost–sharing	$1,800	1992	$ 2,800
Transitional			
Cost–sharing	$3,000*	1992	$ 4,600*
No cost–sharing	$2,700	1992	$ 4,100
All services	$7,000	1985	$16,800

*Minus cost–sharing

The bill also requires the Department of Health and Family Services to annually report to the governor and legislature on the change in coverage limits necessary to conform with the change in the federal consumer price index for medical costs.

ANALYSIS FROM 0288/1

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Under current law, the treatment records of an individual who is treated for mental illness, developmental disabilities, alcoholism, or drug dependence must remain confidential, are privileged to the individual, and may be released only with the individual's informed written consent. However, numerous exceptions apply that permit the release of treatment records without informed written consent. One of the exceptions permits the release of information contained in a treatment record as to whether or not an individual is a patient at an inpatient facility; and the information may be released to the individual's parents, children, or spouse, to a law enforcement officer who is seeking to determine if the individual is on unauthorized absence from the facility, and to mental health professionals who are providing treatment to the individual.

This bill changes that exception to *require* that notice be provided as to whether or not an individual is a patient at an inpatient facility and, if no longer a patient, the facility to which the individual was transferred or other place, if known, at which the individual is located. This information must be released to the individual's siblings, as well as the individual's parents, children, or spouse, or to a law enforcement officer or mental health professional. However, the bill prohibits the release of the information to the individual's parents, children, siblings, or spouse if the individual has specifically named the person and requested that the information be withheld from him or her.

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For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

***-0293/2.1* SECTION 1.** 20.435 (4) (b) of the statutes is amended to read:

20.435 **(4)** (b) *Medical assistance program benefits.* Biennially, the amounts in the schedule to provide the state share of medical assistance program benefits administered under s. 49.45, to provide medical assistance program benefits administered under s. 49.45 that are not also provided under par. (o), to fund the pilot project under s. 46.27 (9) and (10), to provide the facility payments under 1999 Wisconsin Act 9, section 9123 (9m), to fund services provided by resource centers under s. 46.283 and for services under the family care benefit under s. 46.284 (5). Notwithstanding s. 20.002 (1), the department may transfer from this appropriation to the appropriation under sub. (7) (kb) funds in the amount of and for the purposes

specified in s. 46.485. Notwithstanding ss. 20.001 (3) (b) and 20.002 (1), the department may credit or deposit into this appropriation and may transfer between fiscal years funds that it transfers from the appropriation under sub. (7) (kb) for the purposes specified in s. 46.485 (3r). Notwithstanding s. 20.002 (1), the department may transfer from this appropriation to the appropriation account under sub. (7) (bd) funds in the amount and for the purposes specified in s. 49.45 ~~(6v)~~ (6L).

***-0293/2.2* SECTION 2.** 20.435 (7) (bd) of the statutes is amended to read:

20.435 **(7)** (bd) *Community options program; pilot projects; family care benefit.* The amounts in the schedule for assessments, case planning, services, administration and risk reserve escrow accounts under s. 46.27, for pilot projects under s. 46.271 (1), to fund services provided by resource centers under s. 46.283 (5), for services under the family care benefit under s. 46.284 (5) and for the payment of premiums under s. 49.472 (5). If the department transfers funds to this appropriation from the appropriation account under sub. (4) (b), the amounts in the schedule for the fiscal year for which the transfer is made are increased by the amount of the transfer for the purposes specified in s. 49.45 ~~(6v)~~ (6L). Notwithstanding ss. 20.001 (3) (a) and 20.002 (1), the department may under this paragraph transfer moneys between fiscal years. Except for moneys authorized for transfer under this appropriation or under s. 46.27 (7) (fm) or (g), all moneys under this appropriation that are allocated under s. 46.27 and are not spent or encumbered by counties or by the department by December 31 of each year shall lapse to the general fund on the succeeding January 1 unless transferred to the next calendar year by the joint committee on finance.

***-0083/1.1* SECTION 3.** 46.03 (44) of the statutes is created to read:

46.03 **(44)** SEXUALLY TRANSMITTED DISEASE TREATMENT INFORMATION. Promulgate a rule specifying the information that a physician, physician assistant, or advanced practice nurse prescriber may provide, in writing, to a patient under s. 448.035 (3) and encourage physicians, physician assistants, and advanced practice nurse prescribers to provide such information to a patient under s. 448.035 (3). The information shall consist of information about sexually transmitted diseases and their treatment and about the risk of drug allergies. The information shall also include a statement advising a person with questions about the information to contact his or her physician or local health department, as defined in s. 250.01 (4).

–4038/1.1 **SECTION 4.** 46.277 (1) of the statutes is amended to read:

46.277 **(1)** LEGISLATIVE INTENT. The intent of the program under this section is to provide home or community–based care to serve in a noninstitutional community setting a person who meets eligibility requirements under 42 USC 1396n (c) and is relocated from an institution other than a state center for the developmentally disabled or meets the level of care requirements for medical assistance reimbursement in a skilled nursing facility or an intermediate care facility, except that the number of persons who receive home or community–based care under this section is not intended, other than under sub. (4) (c), to exceed the number of nursing home beds that are delicensed as part of a plan submitted by the facility and approved by the department. The intent of the program is also that counties use all existing services for providing care under this section, including those services currently provided by counties.

–4038/1.2 **SECTION 5.** 46.277 (1m) (a) of the statutes is renumbered 46.277 (1m) (ak).

–4038/1.3 **SECTION 6.** 46.277 (1m) (ag) of the statutes is created to read:

46.277 **(1m)** (ag) "Delicensed" means deducted from the number of beds stated on a facility's license, as specified under s. 50.03 (4) (e).

***–4038/1.4* SECTION 7.** 46.277 (2) (intro.) of the statutes is amended to read:

46.277 **(2)** DEPARTMENTAL POWERS AND DUTIES. (intro.) The department may request a waiver from the secretary of the federal department of health and human services, under 42 USC 1396n (c), authorizing the department to serve medical assistance recipients, who meet the level of care requirements for medical assistance reimbursement in a skilled nursing facility or an intermediate care facility, in their communities by providing home or community–based services as part of medical assistance. ~~The~~ Except under sub. (4) (c), the number of persons for whom the waiver is requested may not exceed the number of nursing home beds that are delicensed as part of a plan submitted by the facility and approved by the department. If the department requests a waiver, it shall include all assurances required under 42 USC 1396n (c) (2) in its request. If the department receives this waiver, it may request one or more 3–year extensions of the waiver under 42 USC 1396n (c) and shall perform the following duties:

***–4038/1.5* SECTION 8.** 46.277 (3) (a) of the statutes is amended to read:

46.277 **(3)** (a) Sections 46.27 (3) (b) and 46.275 (3) (a) and (c) to (e) apply to county participation in this program, except that services provided in the program shall substitute for care provided a person in a skilled nursing facility or intermediate care facility who meets the level of care requirements for medical assistance reimbursement to that facility rather than for care provided at a state center for the developmentally disabled. ~~The~~ Except in sub. (4) (c), the number of persons who receive services provided by the program under this paragraph may not exceed the number of nursing home beds, other than beds specified in sub. (5g) (b),

that are delicensed as part of a plan submitted by the facility and approved by the department.

–4038/1.6 **SECTION 9.** 46.277 (3) (b) 1. of the statutes is amended to read:

46.277 **(3)** (b) 1. ~~If~~ Except under sub. (4) (c), if the provision of services under this section results in a decrease in the statewide nursing home bed limit under s. 150.31 (3), the facility affected by the decrease shall submit a plan for delicensing all or part of the facility that is approved by the department.

–4038/1.7 **SECTION 10.** 46.277 (3) (b) 2. of the statutes is amended to read:

46.277 **(3)** (b) 2. Each county department participating in the program shall provide home or community–based care to persons eligible under this section, except that the number of persons who receive home or community–based care under this section may not exceed, other than under sub. (4) (c), the number of nursing home beds, other than beds specified in sub. (5g) (b), that are delicensed as part of a plan submitted by the facility and approved by the department.

–4038/1.8 **SECTION 11.** 46.277 (4) (a) of the statutes is amended to read:

46.277 **(4)** (a) Any medical assistance recipient who meets the level of care requirements for medical assistance reimbursement in a skilled nursing facility or intermediate care facility is eligible to participate in the program, except that the number of participants may not exceed, other than under par. (c), the number of nursing home beds, other than beds specified in sub. (5g) (b), that are delicensed as part of a plan submitted by the facility and approved by the department. Such a recipient may apply, or any person may apply on behalf of such a recipient, for participation in the program. Section 46.275 (4) (b) applies to participation in the program.

–4038/1.9 **SECTION 12.** 46.277 (4) (b) of the statutes is amended to read:

46.277 **(4)** (b) To the extent authorized under 42 USC 1396n and except under par. (c), if a person discontinues participation in the program, a medical assistance recipient may participate in the program in place of the participant who discontinues if that recipient meets the level of care requirements for medical assistance reimbursement in a skilled nursing facility or intermediate care facility, except that the number of participants may not exceed the number of nursing home beds, other than beds specified in sub. (5g) (b), that are delicensed as part of a plan submitted by the facility and approved by the department.

–4038/1.10 **SECTION 13.** 46.277 (4) (c) of the statutes is created to read:

46.277 **(4)** (c) The department may, under this paragraph, provide funding under this section for services for a medical assistance recipient who relocates from a facility to the community, beginning on the date of the relocation and ending on the date that the individual discontinues participation in the program or no longer meets the level of care requirements for medical assistance reimbursement in a skilled nursing facility or an intermediate care facility. Funding for medical assistance costs for individuals relocated under this paragraph may not exceed, in the aggregate, total medical assistance costs for the individuals if served in facilities. The total number of individuals who may participate in the program under this paragraph is not restricted by any otherwise applicable limitation on the number of individuals who may participate in the program under this section.

–4038/1.11 **SECTION 14.** 46.277 (5) (g) of the statutes, as created by 2003 Wisconsin Act 33, is amended to read:

46.277 **(5)** (g) The department may provide enhanced reimbursement for services provided under this section to an individual who is relocated to the community from a nursing home by a county department on or after July 26, 2003,

if the nursing home bed that was used by the individual is delicensed upon relocation of the individual or if the individual is relocated under sub. (4) (c). The department shall develop and utilize a formula to determine the enhanced reimbursement rate.

-4038/1.12 **SECTION 15.** 46.277 (5g) (a) of the statutes is amended to read:

46.277 **(5g)** (a) ~~The~~ Except under sub. (4) (c), the number of persons served under this section may not exceed the number of nursing home beds that are delicensed as part of a plan submitted by the facility and approved by the department.

accounts

and (o)

-0293/2.3 **SECTION 16.** 49.45 (6ur) of the statutes is created to read:

49.45 **(6ur)** PHYSICIAN ORDER ENTRY RECORD SYSTEM; INCENTIVE PAYMENTS. From the appropriation under s. 20.435 (4) (b), the department shall annually make an incentive payment to each hospital that establishes, by January 1, 2007, and thereafter continues to maintain a physician order entry record system for provided medical services that, at a minimum, include pharmacy, laboratory, ultrasonography, and radiology services. The incentive payment shall equal 1% of the Medical Assistance reimbursement to the hospital for the previous fiscal year.

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-0293/2.4 **SECTION 17.** 49.45 (6v) of the statutes is renumbered 49.45 (6L).

-0876/1.1 **SECTION ~~18.~~ 18.** 49.46 (1) (a) 1. of the statutes is amended to read:

49.46 **(1)** (a) 1. Notwithstanding s. 49.19 (20), any individual who, without regard to the individual's resources and subject to par. (ar), would qualify for a grant of aid to families with dependent children under s. 49.19.

-0876/1.2 **SECTION ~~19.~~ 19.** 49.46 (1) (a) 1g. of the statutes is amended to read:

49.46 **(1)** (a) 1g. Notwithstanding s. 49.19 (20), any individual who, without regard to the individual's resources and subject to par. (ar), would qualify for a grant

of aid to families with dependent children but who would not receive the aid solely because of the application of s. 49.19 (11) (a) 7.

***–0876/1.3* SECTION 20.** 49.46 (1) (a) 1m. of the statutes is amended to read:

49.46 **(1)** (a) 1m. Any pregnant woman whose income, determined in accordance with par. (ar), does not exceed the standard of need under s. 49.19 (11) and whose pregnancy is medically verified. Eligibility continues to the last day of the month in which the 60th day after the last day of the pregnancy falls.

***–0876/1.4* SECTION 21.** 49.46 (1) (a) 6. of the statutes is amended to read:

49.46 **(1)** (a) 6. Any person not described in pars. (c) to (e) who, without regard to the individual's resources and subject to par. (ar), would be considered, under federal law, to be receiving aid to families with dependent children for the purpose of determining eligibility for medical assistance.

***–0876/1.5* SECTION 22.** 49.46 (1) (a) 9. of the statutes is amended to read:

49.46 **(1)** (a) 9. Any pregnant woman not described under subd. 1., 1g., or 1m. whose family income, determined in accordance with par. (ar), does not exceed 133% of the poverty line for a family the size of the woman's family.

***–0876/1.6* SECTION 23.** 49.46 (1) (a) 10. of the statutes is amended to read:

49.46 **(1)** (a) 10. Any child not described under subd. 1. or 1g. who is under 6 years of age and whose family income, determined in accordance with par. (ar), does not exceed 133% of the poverty line for a family the size of the child's family.

***–0876/1.7* SECTION 24.** 49.46 (1) (a) 11. of the statutes is amended to read:

49.46 **(1)** (a) 11. If a waiver under s. 49.665 is granted and in effect, any child not described under subd. 1. or 1g. who has attained the age of 6 but has not attained the age of 19 and whose family income, determined in accordance with par. (ar), does not exceed 100% of the poverty line for a family the size of the child's family. If a

waiver under s. 49.665 is not granted or in effect, any child not described in subd. 1. or 1g. who was born after September 30,1983, who has attained the age of 6 but has not attained the age of 19 and whose family income, determined in accordance with par. (ar), does not exceed 100% of the poverty line for a family the size of the child's family.

***–0876/1.8* SECTION 25.** 49.46 (1) (a) 12. of the statutes is amended to read:

49.46 **(1)** (a) 12. Any child not described under subd. 1. or 1g. who is under 19 years of age and whose income, determined in accordance with par. (ar), does not exceed the standard of need under s. 49.19 (11).

***–0876/1.9* SECTION 26.** 49.46 (1) (ar) of the statutes is created to read:

49.46 **(1)** (ar) 1. Except as provided in subd. 2. and except to the extent that the determination is inconsistent with 42 USC 1396a (a) (17), for purposes of determining under par. (a) 1., 1g., or 6. whether an individual would qualify for a grant of aid to families with dependent children under s. 49.19 or would be considered, under federal law, to be receiving aid to families with dependent children, or of determining whether an individual meets the income limits under par. (a) 1m., 9., 10., 11., or 12., "income" includes income that would be included in determining eligibility for aid to families with dependent children under s. 49.19 and excludes income that would be excluded in determining eligibility for aid to families with dependent children under s. 49.19.

2. Notwithstanding s. 49.19 (5), for purposes of determining under par. (a) 1., 1g., or 6. whether an individual would qualify for a grant of aid to families with dependent children under s. 49.19 or would be considered, under federal law, to be receiving aid to families with dependent children, or of determining whether an individual meets the income limits under par. (a) 1m., 9., 10., 11., or 12., (am), or (e),

the department shall exclude from the calculation of farm or self–employment income any amounts claimed for depreciation for income tax purposes.

–0876/1.10 **SECTION 27.** 49.46 (1) (e) of the statutes is amended to read:

49.46 **(1)** (e) If an application under s. 49.47 (3) shows that the ~~individual~~ individual's income, determined in accordance with par. (ar), meets the income limits under s. 49.19, or that the individual meets the income and resource requirements under federal Title XVI or s. 49.77, or ~~that the individual~~ is an essential person, an accommodated person, or a patient in a public medical institution, the individual shall be granted the benefits enumerated under sub. (2) whether or not the individual requests or receives a grant of any of such aids.

–0876/1.11 **SECTION 28.** 49.46 (1) (L) of the statutes is repealed.

–0876/1.12 **SECTION 29.** 49.47 (4) (am) 1. of the statutes is amended to read:

49.47 **(4)** (am) 1. A pregnant woman whose family income, determined in accordance with par. (cg), does not exceed 155% of the poverty line for a family the size of the woman's family, except that, if a waiver under par. (j) or a change in the approved state plan under s. 49.46 (1) (am) 2. is in effect, the income limit is 185% of the poverty line for a family the size of the woman's family in each state fiscal year after the 1994–95 state fiscal year.

–0876/1.13 **SECTION 30.** 49.47 (4) (am) 2. of the statutes is amended to read:

49.47 **(4)** (am) 2. A child who is under 6 years of age and whose family income, determined in accordance with par. (cg), does not exceed 155% of the poverty line for a family the size of the child's family, except that, if a waiver under par. (j) or a change in the approved state plan under s. 49.46 (1) (am) 2. is in effect, the income limit is 185% of the poverty line for a family the size of the child's family in each state fiscal year after the 1994–95 state fiscal year.

–0876/1.14 **SECTION 31.** 49.47 (4) (c) 1. of the statutes is amended to read:

49.47 **(4)** (c) 1. Except as provided in par. (am) and as limited by subd. 3., eligibility exists if income, determined in accordance with par. (cg), does not exceed 133 1/3% of the maximum aid to families with dependent children payment under s. 49.19 (11) for the applicant's family size or the combined benefit amount available under supplemental security income under 42 USC 1381 to 1383c and state supplemental aid under s. 49.77, whichever is higher. ~~In this subdivision~~

(cg) 1. Except as provided in subd. 3., for purposes of determining whether an individual's income meets the income requirements under par. (c), "income" includes earned or unearned income that would be included in determining eligibility for the individual or family under s. 49.19 or 49.77, or for the aged, blind or disabled under 42 USC 1381 to 1385. ~~"Income" does not include~~ and excludes earned or unearned income ~~which~~ that would be excluded in determining eligibility for the individual or family under s. 49.19 or 49.77, or for the aged, blind or disabled individual under 42 USC 1381 to 1385.

–0876/1.15 **SECTION 32.** 49.47 (4) (c) 3. of the statutes is amended to read:

49.47 **(4)** (c) 3. Except as provided in par. (am), no person is eligible for medical assistance under this section if the person's income, determined in accordance with par. (cg), exceeds the maximum income levels that the U.S. department of health and human services sets for federal financial participation under 42 USC 1396b (f).

–0876/1.16 **SECTION 33.** 49.47 (4) (cg) 3. of the statutes is created to read:

49.47 **(4)** (cg) 3. Notwithstanding s. 49.19 (5), for purposes of determining whether an individual under par. (ag) or (am) is eligible for medical assistance, the department shall exclude from the calculation of farm or self–employment income any amounts claimed for depreciation for income tax purposes.